## 41.1.0 Introduction

Wisconsin SeniorCare (SC) is a prescription drug assistance program for Wisconsin residents who are at least 65 years of age and meet the program's eligibility criteria. SC began September 1, 2002.

SC is designed to help seniors with covered prescription drug costs. Eligible participants are issued SC identification cards and may receive SC benefits.

There is neither an asset test nor estate recovery for SC. Participation levels are determined by comparing the anticipated annual income of the fiscal test group (FTG) to a percentage of the Federal Poverty Level (FPL) corresponding to the FTG size.

SC is administered by the Department of Health and Family Services (DHFS), through the Central Application Processing Operation (CAPO). County and tribal agencies are not responsible for determining eligibility, but may need to coordinate with workers in the CAPO for mixed cases. Mixed cases include those persons eligible for SC and:

- Food stamps, **or**
- Medicare premium assistance, **or**
- An unmet Medicaid (MA) deductible, **or**
- Child care assistance, **or**
- Are participating in a Department of Workforce Development (DWD) employment program such as Wisconsin Works (W-2).

Although SC is a subprogram of MA, only the portions of the handbook that are referenced in this appendix apply to SC policy.

## 41.2.0 Application

An individual interested in participating in SC must complete a SeniorCare Application Form (HCF 10076). An application may be obtained from a local Office on Aging, Senior Center, or Aging Resource Center. Applications may also be printed from the Department of Health and Family Services web site at: http://www.dhfs.wisconsin.gov/seniorcare/index.htm
If the applicant is unsure where to obtain an application or wants to have one mailed to him/her, s/he should call 1-800-657-2038 (TTY and translation services are available).

**41.2.0 Applications** (cont.)

A $30 enrollment fee is required as a condition of eligibility. If the enrollment fee is not sent with the application, the eligibility begin date could be delayed (41.5.1).

SC applications should be mailed to:

SeniorCare
P.O. Box 6710
Madison, WI 53716-0710

**NOTE:** For benefit renewal requirements, see 41.15.0.

41.2.1 Application Processing

A valid application for SeniorCare is a SeniorCare Application Form (HCF 10076) with the applicant's:

- Name, **and**
- Address, **and**
- Signature (41.2.2) in Section V. Applications that are not signed in Section V of HCF 10076 will be returned to the applicant. (Section VI of the 07/02 version of HCF 10076.)

However, non-financial (41.3.0) and income (41.6.0) information is needed to determine eligibility.

"General Delivery" may be used for a mailing address but can not be used as a residence address.

The presence of a signature on a SC application indicates intent to apply. When a signed application is received without an enrollment fee, the department will send an enrollment fee request notice to the applicant(s). An application will not be approved until an enrollment fee is received.

When an application is received with an enrollment fee(s) where the applicant(s) has answered "No" to the question "Are you Requesting SeniorCare?", the department will assume that there is a request for at least one person. When an application is received without the enrollment fee where the applicant's answer to the question is "No", the department will follow up with the applicant(s) to determine his/her intent.

The date a valid application is received by the SC program is the application filing date. Eligibility for SC will be determined as soon as possible, but not later than 30 days from the date a valid application is received.

41.2.1 Application Processing (cont.)

A delay in processing the application may occur if there is a delay in obtaining information or in receipt of the enrollment fee necessary for determining eligibility. If a delay occurs, the applicant will be notified in writing that there is a delay in processing the application. The notice will specify the reason for the delay and inform the applicant of his/her right to appeal the delay.

If the initial application is denied and the applicant wishes to reapply, s/he should check the "New Application" box on the application form. "Reapplication" refers to current participants who are requesting establishment of a new benefit period due to a change in circumstances.

41.2.2 Signing the Application

The applicant must sign the application form in Section V of HCF 10076 (Section VI of the 07/02 version of HCF 10076) with his/her signature, a mark or an "X", unless one of the following signs for him/her:

1. A guardian.
2. An authorized representative.
3. A power of attorney/durable power of attorney. (Health Care Power of Attorney is not accepted as proof of authority.)

*41.2.2.1 Witnessing the Signature*

If a SC applicant signs the application form in Section V of HCF 10076 with a mark or an "X", the signature must be witnessed by two individuals. (Section VI of the 07/02 version of HCF 10076)

41.2.3 Authorized Representative

An authorized representative may act on behalf of the SC participant at application and/or reviews, and is authorized to provide information and any documentation that is necessary to establish SC eligibility.

A SC applicant may authorize someone to represent him/her by completing the authorized representative form HCF 10080. (Note: The early version of SC application included Section V for authorizing a representative. If the 07/02 version of HCF 10076 is submitted with Section V completed, SC will accept the authorization of the representative.)

41.2.4 Guardian and Power of Attorney

An applicant is not required to complete the Authorized Representative form HCF 10080 if a legal guardian or power of attorney (POA) is applying on the SC applicant's behalf.

Copies of guardianship or POA documentation will be requested after the SC application has been submitted. Documentation must be submitted to the SC Program before information about the applicant or participant will be released to the guardian or POA. A POA may also be authorized for representation by completing the authorization of representation form (HCF 10080) SeniorCare Authorization of Information in lieu of submitting the POA papers.

**41.3.0 Non-Financial Requirements**

To be non-financially eligible for SC, an applicant must:

1. Be at least 65 years of age.
2. Be a Wisconsin resident.

   A Wisconsin resident is an individual who meets at least one of the following criteria:
   - Has a permanent residence in Wisconsin.
   - Is considered a Wisconsin resident for tax purposes.
   - Is a registered voter in Wisconsin.

   A SC participant may temporarily live outside the State of Wisconsin, as long as s/he maintains permanent residency in Wisconsin. Residency in a Wisconsin nursing home or an assisted living facility will meet this requirement.

3. Be a U.S. citizen or a qualifying legal alien (2.2.0).

   An applicant who is a resident alien will need to provide a copy of both sides of his/her alien card and identify his/her country of origin. If there are discrepancies between reported and verified data, supporting legal documentation must be provided by the applicant. When legal documentation is not available and SSA benefits have been verified, this requirement has been met.

   Verification of alien status can be made through the U.S. Bureau of Citizenship and Immigration Services' Systematic Alien Verification for Entitlement (SAVE) program.

***41.3.0 Non-Financial Requirements (cont.)***

4. Provide a Social Security Number (SSN) or be willing to apply for one (37.3.1).

   Applications without the SSN will not be returned. Applicants will be contacted and given an opportunity to provide a SSN. Eligibility will not be confirmed until the SSN or proof of application for SSN has been supplied. If the SSN or the proof of application is not received within 30 days of application for SC, eligibility will be denied and any enrollment fee received will be refunded. The individual can reapply once they have their SSN. The Eligibility begin date will be based on the new application receipt date.

   If a person requires assistance in obtaining a SSN, the SC Program will assist him/her in applying for one.

5. Not be a full-benefit MA recipient (24.2.0). This includes participants who are covered by Family Care MA. (32.3.0)

   Individuals are not considered MA recipients for SC if they have an unmet MA deductible (20.0.0) or receive one of the following:

   - Medicare premium assistance (27.0.0).
   - Family Care non-MA (32.0.0).
   - TB-related MA (19.7.0).
   - Emergency Services (2.3.0).

6. Not be an inmate of a public institution (40.2.0, #4).

7. Cooperate with providing information and/or verification necessary to determine eligibility (37.2.0) and for quality assurance purposes.

   If a person requires assistance in obtaining the required verification, the SC program will assist him/her.

   If a person is not able to produce the required verification, and the SC program is not able to produce the required verification, the SC program may not deny assistance.

   If a person is able to produce required verification but refuses or fails to do so, the application will be denied.

41.3.1 Enrollment Fee

In addition to the non-financial requirements listed above, each applicant must pay a $30 annual enrollment fee. The enrollment fee must be paid prior to eligibility confirmation. When a participant reapplies for a new benefit period, a new enrollment fee is required

When a SC enrollment fee check is returned for non-sufficient funds, the applicant is mailed a form letter and provided ten calendar days to submit a replacement check. If a replacement check is not received, a form letter giving another 10 days to replace the fee is sent to the participant. If the check is still not replaced, then the eligibility is terminated. A notice of decision is mailed to the participant. The termination date is 10 days after the notice of the decision (mail) date.

*41.3.1.1 Refunds*

**No Application Received**
If CAPO receives a fee without an application a manual notice and application will be sent, if possible, to the individual from whom the fee was received. If an Application is not received by CAPO within 45 days of the receipt of the fee, a refund the will be processed at the request of the person who submitted the fee.

**Application Denied**
Anytime an application for SC is denied, a refund of the paid enrollment fee is automatically issued. A refund may be requested prior to eligibility being confirmed or within specified timelines outlined below.

**Opt out**
Refunds are based on individual participation. A SC participant may receive an enrollment fee refund if s/he received an initial eligibility notification, but has not received any SC prescription drug benefits or services and requests to withdraw from the program (41.12.1).

In all opt-out cases, a refund will be issued only if the request to withdraw from the SC program is made by the later of:

- Ten days following issuance of the eligibility notice, **or**
- 30 days from the application filing date.

The date by which a request for refund must be made will be printed on the initial eligibility determination notice. Filing of a hearing request will not delay these deadlines for refunds.

41.3.1.2 Refunds to Deceased Participants

A refund may also be requested by the family member of a deceased participant when all the following criteria are met:

- S/he received an eligibility notification, **and**
- Death occurs prior to the start of or within 30 days of the beginning of the SC benefit period, **and**
- The request is made within 10 days of the date of death; **and**
- S/he had not received any SC prescription drug benefits or services.

**NOTE:** If all of the above conditions are met, a refund will be issued even if the death is reported beyond the refund deadline date.

41.3.1.3 Opt In

Once the opt-out of eligibility is confirmed, the participant will have 30-days to contact the CAPO if s/he chooses to "opt in" to the program. S/he would need to send another enrollment fee if the original enrollment fee has been refunded. A new application is not required to opt in.

A participant who decides after the 30-day period that s/he wants to rejoin the program will need to complete a new application and submit the enrollment fee.

41.3.2 Age Limitation

A single applicant should apply for SC no sooner than 30 days before his/her 65$^{th}$ birthday.

When a couple applies where one spouse is 65 or older and the other is under 65 at the time of application, only the spouse that is 65 or older can be determined eligible. If both apply, the younger spouse would be denied SC unless s/he is turning 65 within 30 days. If the younger spouse will turn 65 within the 12-month enrollment period, s/he will receive a notice pending his/her eligibility for the enrollment fee approximately one month prior to his/her 65$^{th}$ birthday.

41.3.3 Other Insurance

Applicants who have prescription drug coverage under other health insurance plans, including Medicare Parts A and B, may enroll in SC. SC is the payor of last resort except state funded only programs such as Wisconsin Chronic Disease Program (WCDP) and HIRSP.

41.3.3 Other Insurance (cont.)

SC will coordinate benefit coverage with all other health insurance coverage. SC may also coordinate benefits with pharmacies that accept discount cards. Questions about individual health insurance coverage should be directed to the health insurance company. Questions regarding insurance carriers should be directed to:

Office of Commissioner of Insurance
Bureau of Market Regulation
PO Box 7873
Madison, WI 53707-7873
1-800-236-8517

**41.4.0 Fiscal Test Group (FTG)**

The FTG consists solely of an applicant, unless the applicant is married and resides with his/her spouse.

If the applicant is married and resides with his/her spouse, the FTG consists of both the applicant and his/her spouse. An applicant is considered to be residing with his/her spouse if the permanent residence of the spouse is the same as that of the applicant.

**Exceptions:** The FTG consists only of the applicant if:

- One spouse is institutionalized and is expected to be out of the home for 30 or more days, **or**
- The applicant's spouse is a SSI recipient, **or**
- The applicants are married but are living separately, **or**
- Both spouses are living in a nursing home.

**41.5.0 Benefit Period**

The benefit period for SC is 12 consecutive months. The benefit period and eligibility remain intact unless the participant :

(1) Moves out of state,
(2) Reapplies (41.11.0),
(3) Requests to withdraw from the program (41.12.1), or
(4) Dies.

41.5.1 ID Cards

When an applicant is found eligible for SC, s/he is mailed a plastic SeniorCare ID card and information about how to use it. SC participants who renew their eligibility will continue to use their original card.

41.5.2 Eligibility Begin Date

SC begins on the first day of the month following the month in which all eligibility requirements have been met.

**Exception:** SC eligibility begins the day after MA eligibility ends if a SC application is submitted prior to the MA termination date and all eligibility requirements are met.

**Example.** Carol applies for SC on September 19th and meets all eligibility requirements. Her application is processed on October 10th, and eligibility is confirmed the same day. Carol's benefit period is from October 1st through September 30th.

**Example.** William applied for SC on September 19th but did not submit the enrollment fee with his application. His eligibility "pends" and a notice is issued. William submits the fee on October 1st and eligibility is confirmed the same day. William's benefit period is from November 1st through October 31st.

**Example.** Mary is notified that MA eligibility will end on November 30th because her assets exceed the limit. She applied for SC on November 29th and will meet all SC eligibility requirements on December 1st (when she is no longer an MA recipient). Mary's benefit period is from December 1st through November 30th.

**41.6.0 Financial Requirements**

Income information for SC is based on the applicant's good faith estimate of income for the next 12 months beginning with the month of application. Last year's information from tax returns or other sources may be used as a guide when determining the estimate.

All income should be rounded to the nearest whole dollar when entering the amount on the application or renewal application.

41.6.1 Assets

There is no asset test for SC. In general, cash that is received as a result of converting an asset from one form to another, is not income. This includes withdrawals from savings and/or checking accounts, certificates of deposit, or money market accounts. However, special provisions apply to retirement benefits (41.6.7.1). Income generated from any assets that the SC participant may have is considered budgetable income and must be reported on the application or renewal application.

41.6.1 Assets (cont.)

**Example.** Eric has a savings account with $5,000 in it. Eric's savings account is considered an asset, but the interest that he anticipates earning is countable income.

Eric anticipates withdrawing $1,000 from his savings account during the coming year. This amount does not count as income. It is an asset that has been converted to cash. Only the interest Eric anticipates receiving from the savings account is countable income. Any withdrawals from his savings account are considered the conversion of an asset, and are not counted as income.

41.6.2 Income

The income of a spouse who is in the SC FTG is included in the estimate of the annual budgetable income, even if s/he does not apply or is non-financially ineligible.

Annual income is determined prospectively from the month of application through the next 12 calendar months. Income exempted for MA eligibility is also exempted for SC (15.2.0), including Earned Income Tax Credit (EITC) and income tax refunds (15.5.8).

Budgetable income consists of projected **gross** annual income, except for self-employment income, which uses net income. (41.6.6).

In the following income related sections, policy is defined according to the categories on the SeniorCare Application Form (HCF 10076). All income listed in the following sections should be prospectively budgeted for a 12-month period beginning with the month of application.

41.6.3 Gross Social Security

When reporting anticipated gross annual Social Security income, include any deductions for Medicare Part B and court ordered guardianship fees, alimony and/or child support.

**Exception**: If a SC applicant is receiving Medicare premium assistance (27.0.0), his/her monthly payment already includes the Medicare Part B premium.

The applicant should contact the Social Security Administration at 1-800-772-1213 if s/he does not know his/her Medicare premium amount.

41.6.3 Gross Social Security (cont.)

When the applicant is a surviving spouse receiving benefits under his/her spouse's Social Security number, the amount should be considered the applicant's income and reported under the applicant's income column of the application.

41.6.4 Gross Earnings

Budgetable gross earnings consist of all gross earned income, except for self-employment income, which uses net income (41.6.6). Gross earnings include the following:

- AmeriCorp (15.5.10),
- Contractual Income (15.5.2),
- Governor's Central City Initiative (15.5.7),
- Income In Kind (15.5.1),
- Income Received By Members of a Religious Order (15.4.16, 15.5.13),
- Jury Duty Payments (15.5.4),
- Salary,
- Severance Pay (15.5.12),
- Wage Advances (15.5.5),
- Wages,
- Wages and salaries received from a program funded under Title V – Older Americans Act of 1965 (15.5.14),
- Worker's Compensation (15.5.6),
- Respite Care Payment for Services

41.6.5 Interest and Dividends

The SC applicant must report the estimated gross amount of all interest and dividends that s/he expects to receive in the next 12 months, beginning with the month of application. Sources of interest and dividends include, but are not limited to the following:

- Bonds,
- Certificates of Deposit (CD),
- Checking Accounts,
- Money Market Accounts,
- Savings Accounts
- Stocks,

41.6.5 Interest and Dividends (cont.)

- Capital Gains (41.6.5.1)
- Trusts (41.6.5.2)
- Individual Retirement Accounts (15.4.4)
- Annuities
- Land Contracts (15.4.7)
- Loans (15.4.8)

Payments do not need to be directly received. If they are rolled back into the asset, they still must be reported.

Irrevocable interest that a SC applicant receives for an irrevocable burial trust is not budgetable income.

**Note:** Unlike MA, income that is received irregularly infrequently, and under $20 per month **should** be reported as budgetable income for SC applicants.

*41.6.5.1 Capital Gains*

Budgetable income consists of all anticipated capital gains that would be reportable as capital gains to the IRS for tax purposes. All anticipated losses should be subtracted from the gross capital gains amount, and the net capital gain amount should be reported if it is greater than zero. Negative amounts should not be reported and shall not be used to offset other types of income.

The principal or initial investment in the capital asset that the person receives in cash when s/he sells the asset is not considered income. That portion is considered a conversion of an asset from one form to another.

*41.6.5.2 Trusts*

All anticipated payments (including interest, dividends, rent, and withdrawals from principal) from a trust to the applicant are counted as income.

Irrevocable interest that a SC applicant receives for an irrevocable burial trust is not budgetable income.

**Note:** Unlike MA, withdrawals from principle **are** counted for SC as income in the month received.

*41.6.5.3 Joint Savings*

Each person who is a holder in a joint savings account is assigned an equal share of the interest earned. The applicant/applicant's spouse should report only his/her share of the interest.

*41.6.5.3 Joint Savings*

If the applicant and his/her spouse are not living together and hold a joint savings account, the applicant should only report his/her share of the interest .

41.6.6 Self-Employment Earnings

SC will budget net self-employment income, which is calculated by deducting estimated business expenses, losses, and depreciation from gross self-employment income.

If the net self-employment earnings are anticipated to be a loss, the amount should be reported as zero.

Negative amounts should not be reported and shall not be used to offset other income. (22.5.2)

*41.6.6.1 Rental Income*

If rental income is reported to the IRS as self-employment income and is subject to the federal self-employment tax for rental income (usually real estate agents or individuals in a business where extensive services are provided to the renters), depreciation should also be deducted from the gross rental income.

Refer to 41.6.8.3 if rental income is not reported as self-employment income.

**Note:** See section 15.5.3, items #1 and 2, for more information about calculating net rental income for SC participants.

41.6.7 Gross Pension

Examples of income that should be included in the gross pension amount include:

- Railroad Retirement Benefits,
- Retirement Benefits (41.6.7.1),
- Veteran's Benefits. (15.2.27)

*41.6.7.1 Retirement Benefits*

Retirement benefits are work-related plans for providing income when employment ends (e.g., pension, disability, or retirement plans administered by an employer or union). Other examples are funds held in an individual retirement account (IRA) and plans for self-employed individuals, sometimes referred to as Keogh plans.

*41.6.7.1 Retirement Benefits*

Retirement accounts, including individual retirement accounts (IRA), Keogh, etc., are assets, and are therefore not counted for SC.

Periodic payments received from a retirement account or annuity are counted as income. A periodic payment is any partial payment from a retirement account. Withdrawal of the full amount from any retirement account that has never had a withdrawal made from it is not considered a periodic payment and is not countable income.

**Note:** Rolling over an IRA (transferring the funds from one IRA to another) is the conversion of an asset from one form to another. Any potential income from an IRA rollover is countable income for SC.

**Example.** Mike owns a $2000 IRA and plans to withdraw all of it this year. Mike has not withdrawn any money from this IRA in the past.

If Mike withdraws the full $2,000 at one time, the $2,000 continues to be considered an asset. This is a conversion from one form of an asset to another.

If Mike were planning to make a one time withdrawal of $1,000 of the $2,000 from his IRA in the next 12 months, the $1,000 would be considered income on his SeniorCare application.

If Mike were planning to withdraw $100 monthly from his IRA in the next 12 months, the $100 he plans to receive monthly from the IRA is counted as income on his SeniorCare application.

41.6.8 Other Income

Examples of other income are:

- Allocated income from a MA recipient spouse (41.6.8.1),
- Child Support (15.4.14),
- Federal Farm Subsidy (41.6.8.2),
- Gifts (15.4.6),
- Profit sharing (15.4.15),
- Sick/Disability benefits (15.4.2),
- Rental income (41.6.8.3),
- Unemployment Compensation (15.4.3),
- Veteran’s Disability Payments (41.6.8.4)

*41.6.8.1 Allocated Income from a MA Recipient's Spouse*

SC applicants with an MA recipient spouse living outside of the home (e.g. in a nursing home) must report the spousal income allocation amount (23.6.0) as income.

**Example.** Betty is an MA recipient and in the nursing home. She is allowed to allocate up to $1,000 to her spouse, Carl, according to the notice she receives. Betty only actually has $650 available, and of that $45 is set aside as her personal needs allowance. $605 per month that she allocates to Carl would be counted as unearned income for Carl. He would report $7,260 as "Other Income" on his SeniorCare Application.

A SC applicant with an MA recipient spouse living in the home (e.g. a community waivers participant) should not report income that is allocated to him/her. The allocated amount must be included in the income estimate for the MA recipient spouse, because s/he is living in the home.

*41.6.8.2 Farm Subsidy*

The SC applicant must report anticipated farm subsidy payments. The SC applicant must also report payments from the Conservation Reserve Enhancement Program (CREP), a program where the landowner is paid to install conservation practices for a period of 10 to 15 years.

*41.6.8.3 Rental Income*

All expected rental income will be budgeted for SC. Annual operating expenses should be deducted from the annual amount of gross rental income. Operating expenses include ordinary and necessary expenses such as insurance, utilities, taxes, advertising for tenants, and repairs. Repairs include expenses such as repainting, fixing gutters or floors, plastering and replacing broken windows.

Refer to 41.6.6.1 if rental income is reported to the IRS as self-employment income.

41.6.8.4 Veterans' Disability

Veterans' disability payments should be reported as income.

Do not count as income the portion of a veterans disability payment that is for: unusual medical expenses, aid and attendance, or a housebound allowance

41.6.8.4 Veteran's Disability (cont.)

The applicant should check with the Veterans Administration at 1-800-827-1000 to determine if any portion of the payment is considered an allowance for unusual medical expenses, aid and attendance, or housebound allowance.

Reimbursement from the Veterans Administration for medical costs does not count as income.

*41.6.9 Disregarded Income*

The applicant should not report income anticipated from any of the following:

- Active Corp. of Executives (ACE) (15.2.2)
- Adoption assistance payments (15.2.19)
- Agent Orange Settlement Fund payments (15.2.10)
- Disaster and emergency assistance payments made by federal, state, county and local agencies or other disaster assistance agencies (15.2.4)
- Earned Income Tax Credit (11.7.8)
- Earnings of a census enumerator (15.2.2)
- Emergency Fuel Assistance payments (15.2.2)
- Foster Care payments (15.2.18)
- Foster Grandparents Program (15.2.2)
- Governmental rent or housing subsidies (15.2.2)
- Homestead Tax Credit (15.2.2)
- Income Tax Refunds (both state and federal) (11.7.7)
- Individual Development Account payments (15.2.5)
- Kinship Care payments (15.2.24)
- Low-Income Energy Assistance Program (15.2.2)
- Older American Community Service Program (except for wages or salaries which are counted) (15.2.2)
- Payments made to individuals because of their status as victims of Nazi persecution (15.2.12)
- Payments received from the class action settlement of Susan Walker vs. Bayer Corporation. These payments are to hemophiliacs who contracted the HIV virus from contaminated blood products (15.2.22).
- Penalty payments made when the state does not correctly process child support refunds.
- Radiation Exposure Act program payments made to compensate injury or death due to radiation from nuclear testing and uranium mining (15.2.11).
- Reimbursement from private insurance company for medical, long-term care, or dependent care expenses (15.2.8).
- Restitution payments to individual Japanese-Americans (or

*41.6.9 Disregarded Income* (cont.)

their survivors) and Aleuts who were interned or relocated during WWII (15.2.20).

- Retired Senior Volunteer Program (RSVP) (15.2.2)
- Reverse mortgage payments (11.7.2.1)
- Service Corp. of Retired Executives (SCORE) (15.2.2)
- University Year for Action Program (15.2.2)
- Volunteers in Service to America (VISTA) (15.2.2)
- W-2 payments for transitional jobs and community service jobs (15.2.25)
- Wisconsin's Family Support Program (15.2.2)
- Do not count payments from Indian Health Services. **Note: Payments to Native Americans listed in 15.2.1 must be counted.**

**41.7.0 Participation Levels**

For applicants determined eligible, SC pays for a portion of covered prescription drugs (41.16.0), depending on the person's participation level.

Effective with benefit periods starting September 1, 2003 there are four participation levels. The level of benefits an applicant receives depends on his/her annual income and, for some, on the amount they spend on covered prescription drugs during their 12-month benefit period.

The participation levels are:

- **Level 1: Co-Payment**
  (Annual income is at or below 160% of the FPL.)
- **Level 2a: Deductible $500**
  (Annual income is greater than 160% of the FPL and less than or equal to 200% of the FPL.)
- **Level 2b: Deductible $850**
  (Annual income is greater than 200% of the FPL and less than or equal to 240% of the FPL.)
- **Level 3: Spenddown**
  (Annual income is above 240% of the FPL.)

**Note :** The FPL is set annually by the Department of Health and Human Services see 30.14.0.

If the FPL changes during the eligibility determination process or before a redetermination can be completed, the new levels will be used.

| SeniorCare Levels of Participation | |
|---|---|
| **Income Limits*** | **Annual Out-of-Pocket Expense Requirements and Benefits** |
| **Level 1**<br><br>**Income at or below 160% of FPL**<br><br>At or below $14,896 per individual or $19,984 per couple annually.* | • No deductible or spenddown.<br>• $5 co-pay for each covered generic prescription drug.<br>• $15 co-pay for each covered brand name prescription drug. |
| **Level 2a**<br><br>**Income above 160% and at to or below 200% FPL**<br>$14, 897 to $18,620 per individual and $19,984 to $24,980 per couple annually.* | • $500 deductible per person.<br>• Pay the SeniorCare rate for drugs until the $500 deductible is met.<br>• After $500 deductible is met, pay a $5 co-pay for each covered generic prescription drug and a $15 co-pay for each covered brand name prescription drug. |
| **Level 2b**<br><br>**Income above 200% - and at or below 240% of FPL**<br>$18,621 to $22,344 per individual and $24,981 to $29,976 per couple annually. | • $850 deductible per person.<br>• Pay the SeniorCare rate for most covered drugs until the $850 deductible is met.<br>• After $850 deductible is met, pay a $5 co-pay for each covered generic prescription drug and a $15 co-pay for each covered brand name prescription drug. |
| **Level 3**<br><br>**Annual income is above 240% of the FPL**<br>$22,345 or higher per individual and $29,977 or higher per couple annually.* | • Pay retail price for drugs equal to the difference between your income and $22,345 per individual or $29,977 per couple. This is called “spenddown.”<br>• Covered drug costs for spenddown will be tracked automatically. During the spenddown, there is no discount on drug costs.<br>• After spenddown is met, meet an $850 deductible per person.<br>• Pay SeniorCare rate for most covered drugs until the $850 deductible is met.<br>• After the $850 deductible is met, pay a $5 co-pay for each covered generic prescription drug and a $15 co-pay for each covered brand name prescription drug. |

* These income amounts are based on the 2004 federal poverty guidelines, which increase by a small amount each year.

41.7.1. Level 1 : Co-Payment

SC will pay for covered prescription drugs purchased from participating pharmacies except for participant co-payments.

Level 1 participants are required to pay a $5 co-payment for each covered generic prescription drug, and a $15 co-payment for each covered brand name prescription drug.

When there is no generic equivalent, the participant will still have to pay the $15 brand name co-pay.

If a participant has private insurance with a higher co-payment per prescription than SC, the SC co-payment rules will apply and benefits will be coordinated with the private insurance company. Providers who have questions regarding billing/benefit coordination should contact Provider Services Hotline at 1-800-947-9627.

Residents of nursing homes and community based residential facilities will have to pay the usual SC co-payment even when they are required to purchase drugs on less than a monthly basis.

41.7.2 Level 2a: Deductible

Participant has an annual deductible of $500. Participant will get a discount off the retail price for most covered prescription drugs during the deductible period. The discount amount depends on the particular drug prescribed.

After this deductible is met, a level 2a participant is required to pay a $5 co-payment for each covered generic prescription drug, and a $15 co-payment for each covered brand name prescription drug.

When there is no generic equivalent, the participant will still have to pay the $15 brand name co-pay.

41.7.2.1 Level 2b: Deductible

Participant has an annual deductible of $850. Participant will get a discount off the retail price for most covered prescription drugs during the deductible period. The discount amount depends on the particular drug prescribed.

After this deductible is met, a level 2b participant is required to pay a $5 co-payment for each covered generic prescription drug, and a $15 co-payment for each covered brand name prescription drug.

When there is no generic equivalent, the participant will still have to pay the $15 brand name co-pay.

41.7.2.1 Level 2b: Deductible (cont.)

**Note:** If married persons in the same FTG with annual income above 160% of FPL are determined non-financially eligible at different times, the deductible amount is prorated for the spouse who applies later. (41.9.2.1)

41.7.3. Level 3: Spendown

Level 3 participants must meet a spenddown. The amount of spendown is the difference between the FTG annual income and 240% of the FPL corresponding the size of the FTG. The SC program tracks the amount spent on covered prescriptions drugs that can be applied to an applicant's spendown.

*41.7.3.1 Level 3: FTG of One*

A SC participant considered as a FTG of one with gross annual income above 240% FPL pays retail prices for covered prescription drugs until those payments equal the spenddown amount.

After the spenddown has been met by purchasing drugs at regular prices the participant has an annual deductible of $850. During the deductible period the participant will get a discount off the retail price for most covered prescription drugs during the deductible period.

After this deductible is met, s/he is required to pay a $5 co-payment for each covered generic prescription drug, and a $15 co-payment for each covered brand name prescription drug.

When there is no generic equivalent, the participant will still have to pay the $15 brand name co-pay.

**Example.** Dorothy's annual income is $23,344. This is $1,000 more than 240% of the FPL for a FTG of one (30.14.0). Her spenddown amount for the 12-month benefit period is $1,000. Dorothy pays the retail price for her covered prescription drugs until those payments equal the spenddown amount.

If Dorothy meets the spenddown during her benefit period, she can begin purchasing covered prescription drugs at the discounted rate. These costs are applied toward the $850 deductible.

After this deductible is met, Dorothy purchases covered prescription drugs at the co-payment amounts for the remainder of her benefit period.

*41.7.3.2 Level 3: FTG of Two*

Married persons considered as a FTG of two with annual income greater than 240% FPL and in which both spouses are determined non-financially eligible at the same time pay retail price for covered prescription drugs until the spenddown requirement is met. In this case, the spenddown amount is shared, and covered prescription drugs purchased for either person in the married couple will count toward meeting the spenddown requirement, when both are eligible.

After the spenddown has been met, each spouse must meet a

separate $850 deductible requirement. Participants will get a discount off the retail price for most covered prescription drugs during the deductible period. Only the covered prescription drugs purchased for an individual spouse may count toward that spouse's deductible.

After a spouse has met his/her deductible, s/he is required to pay a $5 co-payment for each covered generic prescription drug, and a $15 co-payment for each covered brand name prescription drug.

When there is no generic equivalent, the participant will still have to pay the $15 brand name co-pay.

**Example.** Bob and Alice's annual income is $31,976, which is $2,000 more than 240% of the FPL for a FTG of two (30.14.0). Both spouses are eligible and, for the 12-month benefit period, their joint spenddown amount is $2,000.

Bob and Alice pay for their covered prescription drugs at retail price until the $2,000 spenddown is met. Covered prescription drugs purchased for either Bob or Alice will count toward the spenddown requirement.

After Bob and Alice meet the spenddown, each person has a $850 deductible. Only covered prescription drugs purchased for Bob count toward his deductible, and only covered prescription drugs purchased for Alice count toward her deductible.

Bob meets his deductible in two months. He then purchases covered prescription drugs at the co-payment amounts for the remainder of his benefit period. Alice meets her deductible in three months. She then purchases covered prescription drugs at the co-payment amounts for the remainder of her benefit period.

*41.7.3.2 Level 3: FTG of Two* (cont.)

If only one spouse in a married couple is determined eligible, only his/her costs count toward the spenddown. S/he pays retail price for covered prescription drugs until the spenddown requirement is met.

**Example.** Tracy and Dave's annual income is $ 31,976, which is $2,000 more than 240% of the FPL for a FTG of two (30.14.0). Because Tracy is 63 years old, only Dave is eligible for SC. For the 12-month benefit period Dave's spenddown amount is $2,000.

Tracy and Dave pay for their covered prescription drugs at retail price. Only covered prescription drugs purchased for Dave count toward the spenddown requirement.
After Dave has met the $2,000 spenddown, he has a $850 deductible. Only covered prescription drugs purchased for Dave count toward his deductible.

After Dave meets his deductible, he purchases covered prescription drugs at the co-payment amounts for the remainder of her benefit period.

**41.8.0 Countable Costs**

In order for the prescription drug purchase to count towards meeting a spenddown or deductible, it must be:

1. Prescribed for the eligible SC participant,
2. Purchased during the benefit period, and
3. Covered by the SC program (41.16.0).

All covered prescription drug costs the participant incurs will be tracked, and the SC Program will coordinate coverage with insurance companies. If the prescription is covered by insurance, only the portion not paid by insurance is applied toward the spenddown or deductible.

When a participant's out-of-pocket expense requirements are met for a deductible or spenddown, participating pharmacies will be informed.

41.8.1 Carryover

There is no carryover of prescription costs from one benefit period to the next. There are two instances, **within a benefit period,** when carryover covered prescription amounts are applied.

41.8.1 Carryover (cont.)

1. When the covered prescription cost exceeds the remaining deductible amount, SC pays the difference.

> **Example.** Jeff earns between 160% and 200% of the FPL for a FTG size of one (30.14.0). He is eligible for SC and has a $500 deductible. In three months, Jeff has a remaining deductible amount of $30.
>
> During the fourth month of his benefit period, with a $30 remaining deductible, Jeff purchases a covered prescription drug that costs $100. The pharmacist informs him that he owes $30 of the $100 prescription drug cost. He has met his deductible. The remaining $70 will be paid by SC.
>
> For the next prescriptions that Jeff has filled during his benefit period, he will pay only co-payment amounts.

*2.* When the cost of a covered prescription drug is applied toward meeting the spenddown and the amount exceeds the remaining spenddown amount, the excess will be applied toward the deductible.

> **Example.** Rachel earns $24,144, which is $1,800 more than 240% of the FPL for a FTG of one (30.14.0). Her spenddown amount for the 12-month benefit period is $1,800. In four months Rachel has incurred all but $50 of her spenddown amount by purchasing covered prescription drugs at retail price.
>
> During the fifth month of her benefit period, when she has $50 of her spenddown left, Rachel purchases a covered prescription drug that costs $100. Rachel pays the full $100. Of the $100, $50 is applied to her spenddown, and $50 is applied to her deductible. She now has satisfied the spenddown, and the remaining deductible amount is $800.

*41.8.2 Date of Purchase*

A prescription is considered purchased on the date the prescription is filled. For the drug purchase to count toward either the spenddown or the deductible, the prescription must have been purchased during the benefit period.

**41.9.0 Addition of a Spouse**

The following exceptions apply when one spouse (hereafter referred to as Spouse 2) is determined eligible after the participating spouse's (hereafter referred to as Spouse 1) benefit period has begun.

In all of these situations, Spouse 1's eligibility and benefit period does not change, unless s/he chooses to reapply (41.11.0).

If Spouse 2 becomes eligible after Spouse 1's benefit period has begun, Spouse 2's benefit period ends on the same date that Spouse 1's benefit period ends.

The participation level for Spouse 2 depends on whether:

1. Spouse 2 was married and living with Spouse 1 at the time of Spouse 1's application (41.9.1).

   - If spouse 1's eligibility was determined at level 2a or 2b, then refer to (41.9.1)

   - If spouse 1's eligibility was determined at level 3 then refer to ( 41.9.1.2)

     a. Met spenddown (41.9.1.2.1)

     b. Unmet spendown (41.9.1.2.2)

**Or**

2. Spouse 2 was not included in the FTG ( e.g. single or not living with Spouse 1) at the time of Spouse 1's application. (41.9.2), but the are now residing together.

   - If spouse 1's eligibility was determined at level at level 2a or 2b, refer to (41.9.2.1)

   - If spouse 1's eligibility was determined at level 3, refer to (41.9.2.2)

**See Summary Table on page 33**

41.9.1 Adding a Spouse No Change in FTG

If Spouse 2' s participation level is determined after Spouse 1's and Spouse 2 was included in the original FTG (married and living with Spouse 1 at the time of Spouse 1's application) the participation level for Spouse 2 is determined based on annual income information provided on Spouse 1's application.

**Example.** Tyler and Anne are married and live together. Tyler has significant prescription drug expenses and applies for SC. Anne takes no prescription drugs and does not request SC when Tyler applies in March. Tyler's participation level is based on a FTG of two. Tyler is found eligible, and his benefit period begins April 1st.

In September, Anne is diagnosed with a health problem and begins taking prescription drugs. She applies for SC on September 15th. The same income information provided in March is used to determine Anne's eligibility, even though Tyler has since obtained a part-time job and has additional income.

Anne's benefit period is from October 1st through March 31st so her benefit period ends at the same time as Tyler's. They will report the income from Tyler's part-time job when their SC eligibility is reviewed in March.

*41.9.1.1 Adding a Spouse No FTG Change At Levels 2a and 2b*

Spouse 2's deductible is prorated if the couple's gross annual income is between 160% and 240% of the FPL, and Spouse 2 becomes SC eligible after Spouse 1's benefit period has begun. To prorate the deductible, multiply the required deductible amount ($500/$850) by the number of months in Spouse 2's benefit period and divide by 12.

**Example.** Mary and Jim apply for SC in January. They have an annual income of $22,000, which is between 160% and 200% of the FPL for a FTG of two (30.14.0). Their income places them in Level 2a ($500 deductible).

Jim is determined eligible for SC, but Mary's eligibility for SC is denied because she is 64. Mary is refunded her enrollment fee. Jim's 12-month benefit period begins February 1st. Jim has a $500 deductible.
In June, Mary will turn 65. At adverse action in the month of May, CARES will process this case through batch. At that time, the application status is updated if the applicant who is turning 65 is:

- In an open SC case, **and**
- The individual has requested SC.

A letter is sent to Mary notifying her that if she still wishes to participate in SC, she must submit her $30 annual enrollment fee. If Mary's enrollment fee is received before July 1st, she will be determined eligible beginning July 1st.

Mary's benefit period begins August 1st, and ends January 31st, when Jim's benefit period ends. Mary's deductible is prorated. Since there are six months in her benefit period, $500 is multiplied by six and the total is divided by 12.

$500 x 6=$3,000/12=$250

Mary's deductible is $250. Once Mary meets the $250 deductible by purchasing covered prescription drugs, she is eligible to purchase covered prescription drugs at the co-payment amounts through the remainder of her benefit period.

Jim's eligibility and benefit period are not affected.
If the couple's income were between 200% and 240% of the FPL, the example would be the same except that the $500 deductible would be $850.

*41.9.1.2 Adding a Spouse No FTG Change At level 3*

If the couple's income is greater than 240% of the FPL and Spouse 2 becomes eligible after Spouse 1's benefit period has begun, the procedure differs according to whether the spenddown has been met at the time Spouse 2's eligibility begins.

41.9.1.2.1 Unmet Spenddown

When Spouse 2 is added before Spouse 1 has met the spenddown, covered prescription drug purchases of both spouses will count toward the remaining spenddown requirement.

After the spenddown has been met, both spouses begin to participate at Level 2b, and each will have a deductible requirement. The deductible for Spouse 1 is $850. The deductible for Spouse 2 is prorated (41.9.2.1).

Participants will get a discount off the retail price for most covered prescription drugs during the deductible period.

After a spouse has met his/her deductible, s/he purchases covered prescription drugs at the co-payment amounts for the remainder of the benefit period.

**Example.** Reginald and Elizabeth's joint income is $32,976, which is $3,000 more than 240% of the FPL for a FTG of two. Elizabeth applies in December and is determined eligible for SC effective January 1st. Only Elizabeth's covered prescription drug costs are applied toward the spenddown.
In March, Reginald turns 65 and is determined eligible for SC beginning April 1st. His benefit period ends December 31st, when Elizabeth's ends. Since Elizabeth has not yet met the spenddown when Reginald's eligibility begins, both spouses' covered prescription expenses are applied toward the remaining spenddown amount, beginning April 1st.

In June, Elizabeth and Reginald meet the spenddown. Elizabeth has a $850 deductible, but Reginald's deductible is prorated. Since there are nine months in his benefit period, $850 is multiplied by nine and the total is divided by 12.

$850 x 9 = $7,650/12 = $638

Reginald's deductible is $638. Once Reginald meets the $638 deductible, he purchases covered prescription drugs at the co-payment amounts through the remainder of his benefit period. Once Elizabeth meets her $850 deductible, she purchases covered prescription drugs at the co-payment amounts through the remainder of the benefit period.

*41.9.1.2.2* Met Spenddown

When a second spouse is added after the spenddown has been met, the eligibility and benefit period for Spouse 1 is not affected.

If Spouse 2's income was included in Spouse 1's determination and the spenddown has been met, the deductible for Spouse 2 is prorated (41.9.2.1). Participants will get a discount off the retail price for most covered prescription drugs during the deductible period.

After a spouse has met his/her deductible, s/he purchases covered prescription drugs at the co-payment amounts for the remainder of the benefit period.

**Example.** Bob and Bernice's joint income is $ 30,976, which is $1,000 more than 240% of the FPL for a FTG of two. Bernice applies in December and is determined eligible for SC effective January 1st. Bob does not apply because he is not yet 65 years old. Only Bernice's covered prescription drug costs are applied toward the spenddown amount of $1,000.

Bernice meets the spenddown requirement in April. She then begins purchasing covered prescription drugs that count toward her $850 deductible. In June, she has $100 left before she will meet her deductible.

In May, Bob turns 65 and is determined eligible for SC. His eligibility begin date is June 1st. His benefit period ends December 31st, when Bernice's ends. Since Bernice has already met the spenddown requirement, Bob will begin participating at Level 2b. His deductible will be prorated. Since there are seven months in his benefit period, $850 is multiplied by seven and the total is divided by 12.

$850 x 7 = $5,950/12 = $496

Bob's deductible is $496. After he meets the $496 deductible by purchasing covered prescription drugs, he purchases covered prescription drugs at co-payment amounts for the remainder of his benefit period.

Bernice's eligibility and benefit period are not affected. Once she meets her deductible by purchasing another $100 in covered prescription drugs, she purchases covered prescription drugs at the co-payment amounts for the remainder of her benefit period.

41.9.2 FTG Changes

When a married SC participant applies after Spouse 1's benefit period has begun, and Spouse 2 was not included in the FTG when the participation level for Spouse 1 was determined:

- The gross annual income test for Spouse 2 is based on a FTG of two, **and**
- Gross annual income for Spouse 2 is determined prospectively beginning with the month Spouse 2's request is received, **and**
- The eligibility and benefit period for Spouse 1 is not affected, unless s/he chooses to reapply.

**Example.** Jim is a SC participant from September through August. Because he was not married and living with a spouse when he applied, Jim's benefit level was based on a FTG of one.

In January Jim marries Helen. Helen applies for SC in February. Jim's eligibility is not re-determined when Helen applies.

Helen's participation level is determined based on a FTG of two. Income is estimated for Helen prospectively for the 12-month period beginning in February.

Helen's benefit period begins in March, if she met all eligibility requirements in February. Helen's benefit period ends in August, when Jim's benefit period ends.

41.9.2.1 FTG Changes at Level 2a and 2b

Spouse's 2 deductible is prorated (41.9.2.1) when income for Spouse 2, based on a FTG of two, is determined to be above 160% but less than or equal to 240% of the FPL and Spouse 2 is added to the case after Spouse 1's benefit period has begun.

41.9.2.1 FTG Changes (cont.)

**Example.** Will is married, but he and his wife Grace were separated at the time he applied for SC.

Will applies for SC in October. Will's benefit level is based on a FTG of one, using only his income. Will's gross annual income is $13,176, which is less than 160% of the FPL for a FTG of one.

Will is determined to be SC eligible at Level 1 beginning November 1st. His 12-month benefit period ends the following October. Will does not pay a deductible or spenddown. He purchases covered prescription drugs at the co-payment amounts.

Grace returns home in January. She applies for SC in February and is determined eligible beginning March 1st. Grace's benefit level is determined based on a FTG of two. Their joint income is determined to be $27,656, which is between 200% and 240% of the FPL for a FTG of two. Her benefit period ends October 31st, when Will's benefit period ends.

Since there are eight months in her benefit period, Grace's deductible amount is prorated. The deductible amount of $850 is multiplied by eight and then divided by 12.

$850 x 8=$6,800/12=$567

Grace's deductible amount is $567. After she has met her deductible, she purchases covered prescription drugs at the co-payment amounts for the remainder of the benefit period. Will's eligibility and benefit period are not affected.

*41.9.2.2 FTG Changes* At Level 3

Spouse 2's spenddown is prorated only if:

The income for Spouse 2, based on a FTG of two, is determined to be above 240% of the FPL, **and**

- Spouse 2 becomes eligible after Spouse 1's benefit period has begun, **and**
- Spouse 2 was not included in the FTG when the participation level for Spouse # 1 was determined.

*41.9.2.2 FTG Changes*
At Level 3 (cont.)

To prorate Spouse 2's spenddown, multiply the amount of income exceeding 240% FPL by the number of months of Spouse 2's benefit period and divide by 12. The result is equal to the prorated spenddown amount of Spouse 2. Only covered prescription drug costs of Spouse 2 count toward the prorated spenddown.

After the spenddown has been met, the deductible for Spouse 2 is prorated (41.9.2.1). Participants will get a discount off the retail price for most covered prescription drugs during the deductible period.

After the deductible is met, s/he purchases covered remainder of the benefit period.

**Example.** Tim is married, but his wife Marsha was institutionalized at the time he applied for SC. Marsha was expected to be out of the home for five months.

Tim applies for SC in May. Tim's benefit level is based on a FTG of one. Tim's gross annual income is $13,176, which is less than 160% of the FPL for a FTG of one.

Tim is determined to be SC eligible beginning June 1st. His 12-month benefit period ends the following May. Tim does not pay a deductible or spenddown. He purchases covered prescription drugs at the co-payment amounts.

Tim's wife Marsha returns home in November. She applies for SC in November and is determined eligible beginning December 1st. Marsha's participation level is determined based on a FTG of two. Their joint income is determined to be $30,976**,** which is $1,000 above 240% of the FPL for a FTG of two. Her benefit period ends May 31st, when Tim's benefit period ends.

Since there are six months in her benefit period, Marsha's spenddown amount is prorated. The spenddown amount of $1,000 is multiplied by six and then divided by 12.

$1,000 x 6=$6,000/12=$500

Marsha's spenddown amount is $500. After she has met her spenddown, she then has a prorated deductible. Since there are six months in her benefit period, $850 is multiplied by six and then divided by 12.

$850x 6=$5,100/12=$425

Marsha pays for covered prescription drugs until she has met the $425 deductible. After Marsha has met the deductible, she purchases covered prescription drugs at the co-payment amounts for the remainder of benefit period.

Tim's eligibility and benefit period are not affected

## ADDITION OF A SPOUSE

The following table assumes that Spouse 1 and Spouse 2 do not apply for SC at the same time.

| | **SPOUSE 1's Eligibility** | **SPOUSE 2's Eligibility** |
|---|---|---|
| **Benefit Period**: **Begin Date** | First of month following receipt of a valid application and enrollment fee. | First of month following receipt of a valid application and enrollment fee. Will be later than Spouse 1's begin date. |
| **Benefit Period**: **End Date** | End of twelfth month of eligibility unless terminated early. | Same end date as Spouse 1 regardless of when Spouse 2 applies. |
| **Participation Level:** Married at time of Spouse 1's application | FTG of two. Participation Level determined based on annual self-reported income of both spouses. | FTG of two. Participation Level determined based on annual self-reported income from Spouse 1's application. Eligibility results will be the same as Spouse 1. |
| **Participation Level:** Single or not living together at time of Spouse 1's application. | Gross annual income test based on a FTG of **one**.<br><br>When adding a new spouse, Spouse 1 does not need to reapply until the end of the twelve-month benefit period unless s/he chooses to do so. | Gross annual income test based on a FTG of two. Participation Level determined based on annual self-reported income of both spouses. Participation Level may be different than Spouse 1's. Spouse 2 must estimate income at the time s/he applies. Spouse 1's income remains the same. |
| **Deductible:** | Has a $500/$850 deductible based on Participation Level. | Required deductible is prorated based on number of months of eligibility and amount of deductible. |
| **Spenddown**: Unmet Original FTG of 2 | Covered prescription drugs of Spouse 1 used to meet spenddown until Spouse 2 is added. Once spenddown is met, Spouse 1 has a deductible of $850. | Projected income from Spouse 1's application will be used to determine Spouse 2's eligibility. Covered prescription drugs of both spouses are used to meet the spenddown. Once spenddown is met, Spouse 2 has a prorated deductible. |
| **Spenddown**: Met Original FTG of 2 | No change in spenddown for Spouse 1. | No new spenddown when Spouse 2 is added. Spouse 2 has a prorated deductible. |
| **Spenddown**: Unmet Original FTG of 1 | No change in spenddown for Spouse 1. | Spouse 2 has a prorated spendown and deductible. |
| **Spenddown**: Met Original FTG of 1 | No change in spenddown for Spouse 1. | Spouse 2 has a prorated spendown and deductible. |

**Note:** If Spouse 1 terminates prior to spouse 2's request. A new application is required for a new 12- month benefit period.

**41.10.0 Changes**

The following changes must be reported to the SC Program within ten days:

- Address.
- Household Composition (examples include marriage, divorce, separation).
- Death.

Changes may be reported by phone to the SeniorCare Customer Service Hotline at 1-800-657-2038.

Changes may also be reported by writing to:
SeniorCare
P.O. Box 6710
Madison, WI 53716-0710

Participants are asked to include an SSN on any written correspondence.

If a participant reports any changes before the case has been confirmed in CARES, the new information will be used in his/her SC eligibility determination.

Changes reported after the case has been confirmed in CARES will be applied to the participant's SC benefits as follows:

1. Address change:

   a. Reports of address changes within Wisconsin will result in SeniorCare notices being sent to the new address. SC benefit levels will not change for the current benefit period.

   b. Address changes that result in termination of Wisconsin residency result in discontinuation of SC benefits. Provide the participant with at least 10 days notice before the effective date of an adverse action.

      **Note:** Reporting an out-of-state address does not necessarily signify that an applicant is not a Wisconsin resident (41.3.0).

**41.10.0 Changes** (cont.)

2. Death

A participant's death ends SC eligibility on the date of death. A 10-day notice for adverse action is not required when an adverse action is the result of a participant's death. The "early termination date" for the participant should be equal to the participant's date of death.

If a participant's spouse dies, the participant will remain eligible at the same benefit level through the current SC benefit period. The participant may wish to re-apply to establish a new benefit level if the spouse's death will result in a reduction in income.

3. Change in household composition

If a participant experiences a change in household composition, the SC benefit level will not change through the remainder of the SC benefit period. The participant may wish to re-apply to establish a new benefit level if the change in household composition will result in a better level of participation.

4. Inmate of a public institution (40.2.0).

An inmate of a public institution is ineligible for SC on the date incarceration begins. Provide the participant with adequate notice before the effective date of the adverse action. The "early termination date" is equal to the notice mailing date.

If a participant's spouse is an inmate of a public institution the participant benefit level will remain the same through the current benefit period. The participant may wish to re-apply to establish a new benefit level if the spouse's incarceration will result in a better level of participation.

5. Change in Circumstance

An applicant who wishes to change or correct information on his/her submitted application may do so prior to eligibility being confirmed in CARES.

**41.10.0 Changes** (cont.)

Depending on the nature of a client-reported error or agency discovered error, a participant's eligibility will be re-determined (41.10.1). Provide the participant with at least 10 days notice before the effective date of an adverse action. If the case has already been confirmed in CARES, the applicant may opt out and reapply if s/he so desires.

**Example 1**
Sally and Fred are husband and wife and applied for SC in July. Both Sally and Fred were found eligible with a deductible (Level 2a) for August. In September, Fred loses his job. He reports the change to the SC program. This change will not affect Sally or Fred's SC benefits, because Fred reported the change after his case had been confirmed in CARES. In order to have eligibility redetermined Fred and Sally will need to file a re-application (41.11.0) and submit enrollment fees for each. Without the income from Fred's job, Sally and Fred would be able to purchase prescription drugs at the co-payment level, if a reapplication is filed.

If Fred had reported the change prior to his case being confirmed in CARES, the change would have been applied to Sally and Fred's eligibility determination, and they would have paid the co-payment amounts for prescription drugs. If Fred and Sally wish, they may request to file a reapplication (41.11.0) to change their benefit level.

41.10.1 Correction of Errors

All errors made on the SeniorCare Application (HCF 10076) must be reported by the participant or his/her Authorized Representative, POA, or Guardian to the SeniorCare Customer Services Hotline at 1-800-657-2038 (TTY and translation services are available) or in writing to:

SeniorCare
P.O. Box 6710
Madison, WI 53716-0710

41.10.1 Correction of Errors (cont.)

An error may include, but is not limited to:

- Doubling of income (totaling income on the application).
- Income amounts are off by a factor of 100. (lack of decimal)
- Application processing errors.

An applicant who wishes to change/correct information on his/her submitted application may do so prior to eligibility being confirmed in CARES (41.10.0).

If a participant has been found eligible for either an incorrect SC benefit level or spenddown amount due to an error, action will be taken to correct the mistake. The effective date of the correction is based on whether the error is determined to be Agency Error or Applicant /Participant error, as follows:

41.10.1.1 Agency Error

Agency Error for SC will be determined on a case by case basis. If the error resulted in an overpayment, past benefits are not recoverable. If the error resulted in an underpayment, corrected benefits will be restored back to initial eligibility date of the benefit period.

41.10.1.2 Applicant/Participant Error

If the error resulted in an overpayment, benefit recovery will be pursued and the correction is processed with an effective date based on adverse action notice. Provide the participant with at least 10 days notice before the effective date of an adverse action.

If the error resulted in an underpayment and s/he reported the error within 45 days of the mail date of the notice of decision, restore corrected benefits back to the initial eligibility date of the benefit period. If the error is not reported within 45 days of the notice of decision mail date, the effective date of the correction is the first of the month in which the error is reported.

41.10.1.2 Applicant/Participant Error (cont.)

**Example 1**
In August, Charlie lost this job at the Burger Palace. In September Charlie applied for SC. In his application Charlie erroneously reported income of $1150 per month from the Burger Palace job., Charlie's notice of decision had a mail date of October 1, and stated that Charlie had a $1500 spenddown.

Depending on when Charlie reports this error his benefits may be corrected back to the eligibility begin date or the first month in which the error was reported. (41.10.1).

If he reported the error by November 15, within the first 45 days after the notice of decision mail date, his benefits would be corrected back to the original effective date.

If he reported the error November 16 or later (more than 45 days after the notice of decision mail date), the benefit level change would be made effective the first of the month in which the error was reported.

**Example 2**
Eric applied for SC in July and was determined eligible at level 1 effective August 1st. Prior to applying for SC, Eric got a part-time job that had begun in June. When Eric applied for SC, he neglected to report his anticipated part-time earnings on the SC application.

Eric receives his notice of decision, dated August 8th. The notice informs he is eligible at level 1. Eric reviews the income used in his eligibility determination that is printed in the notice. Eric realizes that he forgot to report his earnings from his part – time job and he calls the CS Hotline on August 21 to report his error.

Eric reports to the CS Correspondent that he is working 10 hours per week and earns $10 per hour. He plans to keep the job as long as possible. He estimates that his earnings will be $5200 for his 12-month benefit period. The only other income that Eric recieves is Social Security. His earnings in addition to the annual Social Security income add up to an annual estimated income of $19,700. Or level 2b.

Since the income correction will result in a negative impact on his eligibility, the effective date of the corrective benefit is October 1, providing Eric with a 10-day notice of the negative action in his case.

41.10.1.2 Applicant/Participant Error (cont.)

Prior to reporting this mistake, Eric had purchased several prescriptions at the co-pay levels with his SC Card. Since the correction resulted in Eric's eligibility at level 2b, he must now meet an $850 deductible between October 1 and July 31 ( the end of his 12- month benefit period), SC will have overpaid Eric's benefits and could seek recovery of the overpaid amount.

41.10.2 Fraud

Fraud is defined as intentionally getting or helping another person get benefits to which s/he is not entitled. Penalties for fraud include a fine of up to $10,000, imprisonment up to one year, or both, and suspension from the SC program.

Fraudulent acts include:

- Intent to provide misleading, fraudulent, omitted, or incomplete information on the SC application;
- Not reporting an event that knowingly affects initial or continued eligibility for SC;
- Applying for SC on behalf of another person and use of any part of the benefit for oneself; or
- Allowing another person to use someone else's card to get prescription drugs.

**41.11.0 Re-Application**

SC participants may request to establish a new SC benefit period at any time. However, it is not beneficial for a SC participant to reapply unless s/he will experience a reduction in gross annual income. The reduction in annual income may occur for reasons varying from loss of income to household composition changes. This could result in SC eligibility at a lower income level resulting in a reduction/elimination of spenddown or deductible.

**41.11.0 Re-Application** (cont.)

Such a change may result from divorce, marriage, institutionalization or death of a spouse, or any other change that results in a significant decrease in income.

To reapply, participants must submit a new application form and pay a $30 enrollment fee per person. Eligibility will be re-determined for a new 12-month period (within 30 days) after a complete application is received.

When eligibility for a new benefit period is determined, the participant's previous benefit period is terminated, and s/he is not allowed to restart the previous benefit period. Any expenses applied to the previous benefit period will not be applied to the new benefit period.

Eligibility for a new benefit period begins on the first day of the month after a complete application is received and all eligibility requirements are met.

**41.12.0 Early Termination**

SC eligibility is terminated prior to the end of the established benefit period if:

- A participant no longer meets non-financial eligibility requirements, **or**
- S/he requests to withdraw from the program, **or**
- S/he requests to establish a new benefit period **and** eligibility for the new benefit period is confirmed (41.11.0).

When SC eligibility has been terminated prior to the end of the established benefit period and the SC Program is notified that all eligibility requirements are again satisfied, within one calendar month of SC eligibility termination, the benefit period is restored.

**Exception:** SC participants who lose SC eligibility solely due to receipt of MA benefits do not have their benefit period terminated; however, they are not eligible for SC benefits or services for the calendar months that they receive MA benefits.

If MA eligibility ends prior to the end of the SC benefit period, and the participant is still SC eligible, SC eligibility automatically resumes.

**41.12.0 Termination** (cont.)

**Example.** Amy applies for SC on October 4th and is determined eligible effective November 1st. In December she applies for MA and is determined eligible, effective December 1st. Amy is not eligible for SC benefits or services while she is receiving MA.

In January, Amy inherits $5,000 and is notified that her MA eligibility ends January 31st, because her assets exceed the limit. Amy still meets SC eligibility requirements, so SC eligibility will resume from February 1st through October 31st.

See 41.15 for termination as it applies to the need for an annual review.

41.12.1 Withdrawal

Applicants or participants may withdraw from the SC Program at any time. To withdraw by phone, call the SeniorCare Customer Service Hotline at 1-800-657-2038.

A request to withdraw can be made in writing to:

SeniorCare
P.O. Box 6710
Madison, WI 53716-0710

A SC participant is eligible for an enrollment fee refund only if s/he meets the requirements listed in 41.3.1.1.

If an applicant chooses to withdraw his/her application prior to eligibility confirmation, s/he will get a refund. If s/he later wishes to “opt in”, s/he will have to re-apply. To re-apply, a new application and enrollment fee are required.

Once eligible, if a participant chooses to “opt-out” and does so within the timeframe for obtaining a refund, s/he will get a refund of the original enrollment fee. If, within thirty calendar days of opting out, the participant requests to opt in, s/he would need to send in another enrollment fee but would not have to send in another application form. Eligibility will be restored back to the beginning of his/her benefit period, once the fee is received and processed.

*41.12.1 Withdrawal (cont)*

The enrollment fee must be received by the deadline identified in the CARES notice to comply with the administrative rule requirement that s/he meets eligibility requirements. If within thirty calendar days of opting out s/he does not contact SC and SC does not receive the enrollment fee, s/he will have to submit a new application and another $30 enrollment fee if s/he wants to come back into the program.

If the participant chooses to opt-out and does not do so within the timeframe for obtaining a refund, s/he will not get a refund. Customer Service should counsel the participant that s/he will not be getting a refund, and s/he can keep his/her case open in the event his/her circumstances change and s/he wants to use the SC benefit in the next 12 months.

If the participant still opts out, but contacts SC within thirty calendar days of opting out to request to opt in, the original enrollment fee that had not been refunded will be applied. S/he will not have to send in another application form. The person will be made eligible back to their original eligibility begin date for that benefit period. This requires a manual work-around because the system will require another $30 enrollment fee to be credited for CARES to process correctly.

**41.13.0 Notice of Decision**

A written notice is sent to the applicant indicating SC certification, benefit reduction, denial, or termination.

The initial notice of decision will provide information regarding total income used for determining participant level. It will also provide the participant with information regarding spenddown, deductible and co-payment amounts.

For reductions, denials or terminations, the notice contains reasons for the action, with any supporting regulations. It also specifies the circumstances under which SC benefits will be continued if a hearing is requested.

SC participants will be notified of an adverse action at least 10 days prior to the effective date of adverse action, except under certain circumstances.

Timely notice requirements do not apply when:

1. A prescription drug billing must be reversed due to an incorrect billing, and that reversal results in a benefit or service change.

**41.13.0 Notice of Decision** (cont.)

2. A participant chooses to withdraw from the program.

3. A participant requests to establish a new benefit period and eligibility for the previous benefit period is terminated (41.11.0).

4. A person is an inmate of a Public Institution.

5. Death of a participant.

**41.14.0 Appeals**

SC applicants, participants or representatives may file an appeal by writing to the Division of Hearings and Appeals (DHA) when one of the following occurs and the action is not the result of a general program policy change:

1. An application is denied, or the person is denied the right to apply.

2. An application is not acted upon within thirty calendar days.

3. A participant believes that the benefits s/he received, or the initial eligibility date of program benefits were not properly determined.

4. Program benefits are reduced, discontinued, suspended, or terminated.

An appeal may result in a hearing.

41.14.1 Requesting a Hearing

The SC applicant or participant, or his/her representative, may request a hearing. The request for a hearing must be made in writing to the DHA within 45 days from the effective date of the adverse action.

Benefits will be continued only if the participant requests a hearing prior to the effective date of the adverse action.

41.14.1 Requesting a Hearing (cont.)

Hearings may be requested by writing to:

Wisconsin Department of Administration
Division of Hearings and Appeals
PO Box 7875
Madison, WI 53707-7875

41.14.2 Hearing

The hearing will be held at a location determined by the DHA.

Hearings will be:

- Held at a time reasonably convenient to the petitioner, department or agency staff and the administrative law judge.
- Reasonably accessible to the petitioner.
- Held on department or agency premises, subject to the judgement of the administrative law judge.
- Accessible to those in need of accommodations for a disability or translation. (For information about an accommodation for a disability or translation for a hearing, call 1-608-266-3096 (voice) or 1-608-264-9853 (TTY).)

**41.15.0 Annual Eligibility Review**

An annual eligibility review is required for each participant byb the end of the current 12 month benefit period, to prevent a gap of in coverage. Eligibility for a new benefit period begins on the first day of the month immediately following the end of the previous benefit period when:

1. A valid pre-printed CARES renewal application or new application form (HCF 10076) is received by the end of the current benefit period, **and**
2. All eligibility requirements are met, including payment of the $30 annual enrollment fee.

Note: For the definition of “valid,” see 41.2.1.

**41.16.0 Benefits**

For all of the participation levels, SC allows the following:

- The generic form of any covered prescription drug, unless the medical practitioner writes on the prescription that the brand name form of the covered prescription drug is medically necessary.
- Insulins are the only general category of over-the-counter drugs that are covered.
- For levels 1 and 2a all prescription drugs covered by

**41.16.0 Benefits** (cont.)

Medicaid. Some limitations apply to prescription drug coverage for levels 2b and 3 if a rebate agreement has not been signed by the drug manufacturer.

- Chemotherapy drugs that are FDA approved and the manufacturer has signed a rebate agreement.

Reimbursement for most drugs is limited to a 34-day supply. Some maintenance drugs may be provided in a 100-day supply.

The co-payment amount is not affected by the # of days in the supply.

NOTE : The participant should contact his/her provider to verify that SC covers a specific drug.

SC does **not** cover the following:

- Prescription drugs administered in a physician's office.
- Prescription drugs that are experimental or have a cosmetic, not a medical purpose.
- Over-the-counter drugs (except for insulin) such as vitamins or aspirin, prilosec OTC, even with a prescription.
- Prescription drugs for which prior authorization has been denied.
- Colostomy supplies and other durable medical supplies (DMS) even though they may need a prescription.
- Prescription drugs for participants in Levels 2b and 3 for which a rebate agreement has not been signed by the manufacturer.

*41.16.1 Discount Pricing*

The discount for a particular drug during the deductible period will be the same at every pharmacy. During the deductible period, the pharmacy must use the SC allowed price.

**Exception:** If a pharmacy's usual and customary charge is less than the SC allowed amount, then the participant would be charged the usual and customary charge and this amount will apply to SC spenddown and/or deductible.

*41.16.2 Early Refills*

When the participant is temporarily leaving the state and the supply on his/her prescriptions is insufficient, s/he will need to make arrangements with the pharmacist to have any additional refills mailed or have someone else pick-up the refill. Postage costs are not covered by SC nor do they count toward the deductible and/or spenddown. Requests for early refills will be denied.

*41.16.3 Out-of-state Pharmacies*

In an emergency, a participant can get a prescription filled out of state and have it count toward SC as long as the participant is within the US, Canada, or Mexico and the pharmacy completes the necessary forms.

Out-of-state pharmacies should contact 1-800-947-9627 to file a claim for reimbursement. Non-emergency prescriptions will be covered only when prior authorization has been granted.